National Institutes of Health, NIH, and the valuable research being done by them. I know how important NIH is to our Nation's future, including its economic well-being. Advances in medical research to prevent, cure, or at least minimize the degree of financial devastation caused by such diseases experienced in the United States is a major reason why it is so necessary that we fund these vital research projects.

That being said, however, I must admit that I have been troubled by several newspaper stories I have read recently concerning the manner in which NIH chooses its spending priorities. One such article appeared in the Washington Post on July 9, and used as its source a recently released report from the Institute of Medicine, IOM.

The roughly 200-page report, entitled ''Scientific Opportunities and Public Needs,'' warns that NIH must do a better job of justifying its spending decisions or it could lose its historically elevated credibility. The premise of the report is that political pressures often play a crucial role and can influence funding decisions.

I have always steadfastly defended the work being done at NIH, and assured its critics that, contrary to what they may think, this was not true. However, when I read the conclusions made by the IOM, I decided to look into this report further. I have with me, Mr. Speaker, a chart. Let us take a look at this chart prepared by the Institute of Medicine on NIH spending priorities.

As Members will note, heart disease is the number one killer in America; 732,400 people die. The spending is $852 million; cancer, 534,300 die. We spend $2,571,000,000.

Let us go further down and look at AIDS–HIV. It is listed as the eighth leading cause of death. It kills 42,100 a year, yet it receives $1.4 billion. The death figures are for 1994 and the spending priorities are for 1996.

Mr. Speaker, in other words, NIH spends approximately $43,000 per death researching AIDS and HIV, while heart disease, which kills over 20 times as many people each year, receives only $1,160 per year per death. Heart disease was the number one killer in 1995, 1996, and 1997. Research dollars at NIH do not reflect this.

According to a Centers for Disease Control, CDC, 1997 report, the top five killers are: cardiovascular disease, one; two, cancer; three, stroke; four, chronic lung disease; five, accidents. Mr. Speaker, note that HIV–AIDS does not even appear in the top five killers, but receives almost the top funding from NIH.

It is very difficult to justify such types of funding disparities. Other diseases, such as diabetes, were responsible for causing 56,700 deaths in 1996, making it the sixth leading cause of death in the United States. By contrast, diabetes research received only $299 million research dollars.

Not only has scientific research made important strides in identifying the causes of certain diseases, it has also launched tests of new drugs to enhance recovery from stroke and spinal cord injury and produce a new drug for the treatment of epilepsy.

In these days of trying to balance the budget, we must not lose sight of the fact that by delaying the onset of diseases such as Alzheimer's, stroke, and cardiovascular disease, we would save almost an estimated $35 million through a reduction in the need for nursing home care.

Now, to my way of thinking, that is not a small amount of money. However, this can only occur if the huge spending increasess that NIH receives do in fact flow to all the institutes, so that all the diseases benefit from these new sources of dollars.

I respect the work being conducted at NIH and believe it has some of the finest first-class scientists and researchers in the world. I would caution, however, that the articles of criticism about the way it runs its shop are becoming more and more frequent. They also need to restructure their priorities based upon the needs. That is my message this afternoon.

Congress has an obligation to ensure that all of its citizens are represented, and this includes how their tax dollars are being spent, especially when it comes to funding for biomedical research.

DISCHARGE PETITION ON PATIENTS' BILL OF RIGHTS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 21, 1997, the gentleman from Iowa (Mr. GANSKE) is recognized during morning hour debates for 5 minutes.

Mr. GANSKE. Mr. Speaker, today I am initiating a discharge petition to force the House to debate House Resolution 486, a rule for consideration of managed care reform bills.

House Resolution 486 provides for the consideration of the Dingell-Ganske Patients' Bill of Rights, and would allow both the manager's substitute amendment and a substitute by one of the leading Republican advocates of managed care reform, the gentleman from Georgia (Mr. CHARLIE NORWOOD).

The gentleman from Georgia (Mr. NORWOOD) could offer the bill developed by the Hastert task force or some other reform plan. Finally, the rule provides for one motion to recommit, with or without instructions.

Mr. Speaker, this week the House may debate House Resolution 4250, the patient protection bill developed by the Hastert task force. This bill just became available for review a few days ago. It has serious problems. It is not the best bill.

I have many concerns which I will not outline today, but let me give just one example. A year or so ago when we passed patient protection legislation as part of the Medicare reform bill, we banned what are called gag rules. These are rules that HMOs set up that prevent doctors or nurses or other health professionals from telling the patients all of the information or treatment options they need.

In our Medicare bill, we said that HMOs could not prohibit or restrict communications. Those last two words are important, ''or restrict.'' They are in the bill that I support, the Patients' Bill of Rights. However, in the Hastert bill, the word ''restrict'' was taken out.

What that means, then, is that an HMO could erect a thousand hurdles that your doctor or nurse would have to jump over to try to tell their patients all of their treatment options. That would be okay, as long as the HMO did not prohibit those types of communications. That is a serious, serious loophole in the legislation, and it is one of the many reasons why I think it is not the best legislation.

I am saying, Mr. Speaker, that it is my intention to testify before the Committee on Rules and to ask that they permit the Dingell-Ganske Patients' Bill of Rights to be offered as an amendment, not merely as a motion to recommit or as a part of some other procedural move. If the Committee on Rules makes such an amendment in order, I can always take my name off this discharge competition.

Mr. Speaker, there are only 33 legislative days left this year. The clock is ticking on our patients. There are many other Republican Members who are concerned that the debate on patient protection legislation be timely and fair.

If the gentleman from Michigan (Mr. DINGELL) and I are not permitted to offer the Patients' Bill of Rights as an amendment, then I will seek to collect Republican signatures on this petition to bring the best HMO reform bill before the House for a fair vote.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12 of rule I, the Chair declares the House in recess until 2 p.m.

Accordingly (at 12 o'clock and 55 minutes p.m.), the House stood in recess until 2 p.m.

□ 1400

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. STEARNS) at 2 p.m.

PRAYER

The Chaplain, Reverend James David Ford, D.D., offered the following prayer:

We are instructed in the Psalms in the scriptures, ''Be still, and know that I am God.''

With so many voices to be heard and many lessons to be understood, it is no wonder that Your still strong voice, gracious God, is not heard. May this moment of prayer allow us to be still